BENNETT FAMILY CHIROPRACTIC, LLC

First Name _____ MI ____ Last _____ Birth Date____/____/____ Age_____ Today's date____/____/____

Address _____ City _____ State _____ Zip _____

Home # (_____)_____ Work # (_____)_____ Ext. _____ Soc. Sec. #_____-_____-_____

____ Male ____ Female Mobile # (_____) _____ E-mail Address _____

# of Children _____ Ages of Children _____ Single Married Significant Other Widowed Separated Divorced

Your occupation _____ Work duties _____ ***WOMEN ONLY: Are you pregnant? No ____ Yes ____***

Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____

Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L / Both
___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L / Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness/ Pain	___Back Stiffness/Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Cancer
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/ Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problems
___Prostate Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness/Vertigo	___Buzzing/Ringing in ears	___Sinus Problems/Allergies	___Nervousness/Anxiety
___Fatigue	___Depression	___ Irritability/Mood Swings	___Tension/Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold feet	___Bed Wetting	___Recurring Infection	___Diarrhea/Constipation./Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw/TMJ Problems
___Cold Sweats	___Light Bothers Eyes	___Problems Urinating	___Heartburn/Reflux
___High Blood pressure	___PMS	___Menopause	___Ulcers
___Other	___Cancer (Type)	___Thyroid	___

Additional Explanation: _____

_____

_____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

_____

When did this condition begin? _____ Has it ever occurred before: Yes No
Was this due to an accident/Trauma? Yes No
If Yes, explain.(ex. fall, auto, work injury, sports,)

_____

Symptoms: When this problem is at it's worst, explain in your own words exactly how it feels?_____

Severity: Mild Moderate Severe

Does this pain travel or radiate? If so, Where? _____

_____

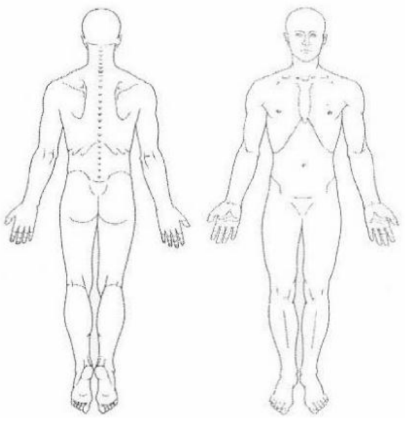
Quality: (circle all that apply)

Burning	Diffuse	Dull/Aching	Localized
Sharp	Shooting	Stabbing	Tingling
Radiating	Other _____		

Is there anything that makes this better? _____

Is there anything that makes this worse? _____

Please mark areas of discomfort on the diagram below.



Timing:

❑ Worse AM ▫ Worse PM ▫ Worse W/ Activity ▫ Worse Sleeping

❑ Occasional (0-25%) ▫ Intermittent (25-50%) ▫ Frequent (50-75%) ▫ Constant (75-100%)

Rate the severity of your symptoms or condition (No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe)
Is the condition getting better, worse, or staying the same? _____
How often do you find yourself suffering from this problem? _____
How long does the problem last? (all the details of timing)_____
What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Changing Positions	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading/Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

Please List any effects that this may have on any Recreational Activities:

_____

Secondary Complaint(s) or symptoms:

_____

Second complaint's severity is a : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Fourth** complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 - 7 – 8 – 9 – 10

Please list any other complaints/conditions/past Accidents & Surgeries. Please list and describe in detail**:**

_____

_____

_____

Medications: What medications are you currently taking and for what conditions?

_____

_____

Is there anything else you think the doctor should know concerning your condition? Yes No

_____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?▫

____ Temporary Relief

____ Correction

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Bennett Family Chiropractic, LLC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Bennett Family Chiropractic, LLC for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ **HR#:** _____ __/__/__

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

HIPPA

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I,_____have read and fully understand the above statements.
(Print name)
I therefore begin my chiropractic examination and any other further care on this basis.

_____ _____

(Signature) (Date)